

LME Alternative Service Request for Use of DMHDDSAS State Funds

For Proposed MH/DD/SAS Service Not Included in Approved Statewide IPRS Service Array

Note: Submit completed request form electronically to Wanda Mitchell, Budget and Finance Team, at Wanda.Mitchell@ncmail.net, and to Spencer Clark, Chief's Office, Community Policy Management Section, at Spencer.Clark@ncmail.net. Questions about completing and submitting this form may be addressed to Brenda G. Davis, CPM Chief's Office, at Brenda.G.Davis@ncmail.net or (919) 733-4670, or to Spencer Clark at Spencer.Clark@ncmail.net or (919) 733-4670.

a. Name of LME The Durham Center		b. Date Submitted 06/13/08
c. Name of Proposed LME Alternative Service Crisis Evaluation and Observation		
d. Type of Funds and Effective Date(s): (Check All that Apply)		
<input type="checkbox"/> State Funds: Effective 7-01-07 to 6-30-08 <input checked="" type="checkbox"/> State Funds: Effective 7-01-08 to 6-30-09		
e. Submitted by LME Staff (Name & Title) Sarah M. Grey, LCSW	f. E-Mail sgrey@co.durham.nc.us	g. Phone No. 919-560-7244

Background and Instructions:

This form has been developed to permit LMEs to request the establishment in IPRS of Alternative Services to be used to track state funds through a fee-for-service tracking mechanism. An LME that receives state single stream or other state non-UCR funding shall use such funding to purchase or start up services included in the Integrated Payment and Reporting System (IPRS) service array and directed towards the approved IPRS target population(s). If the LME wishes to propose the use of state funds for the provision of an Alternative Service that is not included in the IPRS service array, the LME shall submit an ***LME Alternative Service Request for Use of DMHDDSAS State Funds***.

This form shall be completed to fully describe the proposed Alternative Service for which Division approval is requested in order to develop an IPRS reporting code and an appropriate rate for the Alternative Service.

Please use the following template to describe the LME's proposed Alternative Service definition and address all related issues using the standard format and content categories that have been adopted for new MH/DD/SA Services.

Please note that:

- an individual LME Alternative Service Request form is required to be completed for each proposed Alternative Service;
- a separate Request for Waiver is required to be submitted to the Division for the LME to be authorized by the Secretary to directly provide an approved Alternative Service; and
- the current form is not intended to be utilized in SFY 07-08 for the reporting on the use of county funds by an LME. The Division continues to work with the County Funds Workgroup to establish a mechanism to track and report on the use of county funds through IPRS reporting effective July 1, 2008.

Requirements for Proposed LME Alternative Service

(Items in italics are provided below as examples of the types of information to be considered in responding to questions while following the regular Enhanced Benefit Service definition format. Rows may be expanded as necessary to fully respond to questions.)

Complete items in italics as appropriate for all requests.

1	<p>Alternative Service Name, Service Definition and Required Components <i>(Provide attachment as necessary)</i></p> <p>Crisis Evaluation and Observation</p> <p>CEO Services are integrated services that are available 24 hours a day, seven days a week to respond to individuals experiencing a behavioral health crisis. CEO services include screening and assessment; crisis stabilization; and referral back to home environment or linking with services which are not billable under existing service definitions. See number 16 below for program elements and requirements.</p>
2	<p>Rationale for proposed adoption of LME Alternative Service to address issues that cannot be adequately addressed within the current IPRS Service Array</p> <p>Rationale for proposed service includes:</p> <ul style="list-style-type: none"> • <i>Consumer access issues to current service array</i> • <i>Consumer barrier(s) to receipt of services</i> • <i>Consumer special services need(s) outside of current service array</i> • <i>Configuration and costing of special services</i> • <i>Special service delivery issues</i> • <i>Qualified provider availability</i> • <i>Other provider specific issues</i> <p>The Durham Center has determined that addition of Crisis Evaluation and Observation to the IPRS service array will improve capacity to serve consumers in crisis. Frequently consumers experience a crisis that does not clearly rise to the level of inpatient admission or need for facility-based crisis admission. Crisis Evaluation and Observation will allow the provider to conduct more thorough evaluation of the consumer's condition to rule out the need for inpatient level of care for up to 23 hours. This includes consumers on petition who are awaiting a bed at a state facility and allows a billing mechanism for the care and on-going evaluation of such consumers.</p>
3	<p>Description of service need(s) to be addressed exclusively through State funds for which Medicaid funding cannot be appropriately accessed through a current Medicaid approved service definition</p> <p>As proposed above, The Durham Center believes that Crisis Evaluation and Observation is a necessary part of the service array that defines expectations and provides a funding mechanism for consumers whose crisis symptoms warrant careful evaluation to determine if inpatient care is most appropriate or who may improve within 23 hours. There is an additional need for those consumers on petition awaiting transportation or bed availability to be carefully observed and monitored while awaiting such admission.</p>
4	<p>Please indicate the LME's Consumer and Family Advisory Committee (CFAC) review and recommendation of the proposed LME Alternative Service: <i>(Check one)</i></p> <p style="text-align: center;"> <input checked="" type="checkbox"/> Recommends <input type="checkbox"/> Does Not Recommend <input type="checkbox"/> Neutral (No CFAC Opinion) </p>

5	Projected Annual Number of Persons to be Served with State Funds by LME through this Alternative Service 2500
6	Estimated Annual Amount of State Funds to be Expended by LME for this Alternative Service We cannot predict the amount of state money that will be used. We are single stream so none of our claims pay with real dollars. In addition, the timing of claims processing in IPRS can dictate how much money is drawn down for a particular service. Based on the projected number of consumers to serve, 2,500, with an average stay of 20 hours, we can anticipate spending close to \$1M. We have sufficient County money to contribute to this service.
7	Eligible IPRS Target Population(s) for Alternative Service: (Check all that apply) <u>Assessment Only:</u> <input checked="" type="checkbox"/> All <input type="checkbox"/> CMAO <input type="checkbox"/> AMAO <input type="checkbox"/> CDAO <input type="checkbox"/> ADAO <input type="checkbox"/> CSAO <input type="checkbox"/> ASAO <u>Crisis Services:</u> <input checked="" type="checkbox"/> All <input type="checkbox"/> CMCS <input type="checkbox"/> AMCS <input type="checkbox"/> CDCS <input type="checkbox"/> ADCS <input type="checkbox"/> CSCS <input type="checkbox"/> ASCS <u>Child MH:</u> <input checked="" type="checkbox"/> All <input type="checkbox"/> CMSED <input type="checkbox"/> CMMED <input type="checkbox"/> CMDEF <input type="checkbox"/> CMPAT <input type="checkbox"/> CMECD <u>Adult MH:</u> <input checked="" type="checkbox"/> All <input type="checkbox"/> AMSPM <input type="checkbox"/> AMSMI <input type="checkbox"/> AMDEF <input type="checkbox"/> AMPAT <input type="checkbox"/> AMSRE <u>Child DD:</u> <input checked="" type="checkbox"/> CDSN <u>Adult DD:</u> <input checked="" type="checkbox"/> All <input type="checkbox"/> ADSN <input type="checkbox"/> ADMRI <u>Child SA:</u> <input checked="" type="checkbox"/> All <input type="checkbox"/> CSSAD <input type="checkbox"/> CSMAJ <input type="checkbox"/> CSWOM <input type="checkbox"/> CSCJO <input type="checkbox"/> CSDWI <input type="checkbox"/> CSIP <input type="checkbox"/> CSSP <u>Adult SA:</u> <input checked="" type="checkbox"/> All <input type="checkbox"/> ASCDR <input type="checkbox"/> ASHMT <input type="checkbox"/> ASWOM <input type="checkbox"/> ASDSS <input type="checkbox"/> ASCJO <input type="checkbox"/> ASDWI <input type="checkbox"/> ASDHH <input type="checkbox"/> ASHOM <input type="checkbox"/> ASTER <u>Comm. Enhance.:</u> <input checked="" type="checkbox"/> All <input type="checkbox"/> CMCEP <input type="checkbox"/> AMCEP <input type="checkbox"/> CDCEP <input type="checkbox"/> ADCEP <input type="checkbox"/> ASCEP <input type="checkbox"/> CSCEP <u>Non-Client:</u> <input checked="" type="checkbox"/> CDF
8	Definition of Reimbursable Unit of Service: (Check one) <input type="checkbox"/> Service Event <input type="checkbox"/> 15 Minutes <input checked="" type="checkbox"/> Hourly <input type="checkbox"/> Daily <input type="checkbox"/> Monthly <input type="checkbox"/> Other: Explain _____
9	Proposed IPRS <u>Average</u> Unit Rate for LME Alternative Service <i>Since this proposed unit rate is for Division funds, the LME can have different rates for the same service within different providers. What is the proposed <u>average</u> IPRS Unit Rate for which the LME proposes to reimburse the provider(s) for this service?</i> <div style="text-align: right;">\$ 13.06</div>
10	Explanation of LME Methodology for Determination of Proposed IPRS <u>Average</u> Unit Rate for Service (Provide attachment as necessary) To determine the rate for this service, we used the maximum daily reimbursable amount for Facility Based Crisis, \$300.48, and divided it by 23 hours.
11	Provider Organization Requirements This is a service that is offered seven days a week 365 days/year, with a staff to recipient ratio that ensures the health and safety of clients served in the community and compliance with 10NCAC 14R.0104 Seclusion, Restraint and Isolation Time Out. At no time will staff to recipient ratio be less than 1:6 for adult mental health recipients and 1:9 for adult substance abuse

	recipients.
12	<p>Staffing Requirements by Age/Disability <i>(Type of required staff licensure, certification, QP, AP, or paraprofessional standard)</i></p> <p>The program is directed by a physician with adequate nursing staff to assure a medically safe environment. Additional interventions and evaluation may be completed by staff under the direction of a physician. The treatment team should consist of staff who are experienced in the treatment of differing age groups and disability types and include a QP in Developmental Disabilities, a QP in Substance Abuse and a QP who specializes in child treatment.</p>
13	<p>Program and Staff Supervision Requirements</p> <p>Regular and routine clinical and administrative supervision of program supervisors and direct care staff by qualified and trained supervisors and program director. The program must be under the direction of a physician.</p>
14	<p>Requisite Staff Training</p> <p>All direct service staff shall have training in crisis intervention and evaluation including training de-escalation techniques and risk assessment.</p>
15	<p>Service Type/Setting</p> <p>The service shall be provided in a 24 hour facility.</p>
16	<p>Program Requirements</p> <p>The service is designed to permit close observation and ongoing evaluation and stabilization of the consumer in crisis with the goal of keeping the consumer in the community. The service interventions shall be designed to stabilize the presenting crisis, engage natural and community supports, and assist the consumer to plan for further care as clinically indicated. The service is provided 24/7/365 under the direction of a physician with the following elements of the program:</p> <ol style="list-style-type: none"> 1. Ongoing nursing evaluation is available. 2. A comprehensive clinical evaluation is completed to include: <ol style="list-style-type: none"> a) A detailed explanation of the presenting problem and precipitating events. b) Completion of a psychiatric and medical history based on the available information. c) A description of the nature of the consumer's impairments and any safety or risk issues. d) A determination of whether a co-occurring Substance-Related Disorder is present. e) A screening for a history of physical, sexual, or emotional abuse. 3. Maximal attempts are made to coordinate the treatment and affect a timely disposition plan in collaboration with current treatment providers. 4. A comprehensive plan for treatment at the next appropriate level of care is developed. The site for the next level of care and the time of the first appointment are documented. 5. Psychotherapeutic interventions emphasize crisis intervention strategies with the intent to stabilize the consumer. 6. With the consumer's documented consent, an active attempt is made to involve relevant family members and/or support systems. 7. The consumer's primary care physician is consulted if necessary and with the consumer's consent. 8. If not hospitalized, arrangements are made for the consumer to begin services at the appropriate level of care the following day or as soon as possible within 7 days of discharge.

17	<p>Entrance Criteria</p> <p>The recipient is eligible for this service when:</p> <p>A. There is an Axis I or II diagnosis present or the person has a condition that may be defined as a developmental disability as defined in GS 122C-3 (12a)</p> <p>AND</p> <p>B. Level of Care Criteria, Level D/NC-SNAP (NC Supports/Needs Assessment Profile)/ASAM (American Society of Addiction Medicine)</p> <p>AND</p> <p>C. There is evidence of an imminent or current psychiatric emergency, but clear indication for inpatient confinement needs further verification.</p> <p>OR</p> <p>D. Presence of acute and serious functional deterioration, but the member's history suggests that the member is likely to respond adequately within 23 hours to medications, intensive intervention, a structured environment, or brief detoxification.</p>
18	<p>Entrance Process</p> <p>Consumers may access the service in a variety of differing ways including but not limited to referral from a current provider, primary care physician, other crisis service type, hospital emergency room, family or self access.</p>
19	<p>Continued Stay Criteria</p> <p>Length of stay in this service does not exceed 23 hours per crisis event. See discharge criteria below.</p>
20	<p>Discharge Criteria</p> <ul style="list-style-type: none"> • <i>Recipient eligibility characteristics for service discharge</i> • <i>Anticipated length of stay in service (provide range in days and average in days)</i> • <i>Anticipated average number of service units to be received from entrance to discharge</i> • <i>Anticipated average cost per consumer for this service</i> <ol style="list-style-type: none"> 1. Treatment plan goals and objectives have been substantially met and/or a safe, continuing care program can be arranged at a lower level of care. Follow-up aftercare appointment is arranged for within 7 days of discharge 2. The individual no longer meets admission criteria or meets criteria for a less intensive level of care. 3. Either it has been determined that inpatient treatment is appropriate or 4. Consent for treatment is withdrawn it has been determined that involuntary inpatient treatment is inappropriate 5. The individual is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care 6. The individual's physical condition necessitates transfer to a medical facility.
21	<p>Evaluation of Consumer Outcomes and Perception of Care</p> <ul style="list-style-type: none"> • <i>Describe how outcomes for this service will be evaluated and reported including planned utilization of and findings from NC-TOPPS, the MH/SA Consumer (Satisfaction) Surveys, the National Core Indicators Surveys, and/or other LME outcomes and perception of care tools for evaluation of the Alternative Service</i> • <i>Relate emphasis on functional outcomes in the recipient's Person Centered Plan</i> <p>Since this is a very short term service, standard outcome measurement instruments such as NC TOPPS, MH/SA Consumer Satisfaction or NCI surveys would not be applicable.</p>

	<p>Consumer outcomes:</p> <ul style="list-style-type: none"> • 100% of consumers will have a quality crisis plan developed or updated • When medically necessary, consumers will re-engage with provider agency or engage with a new provider agency • Consumers' state hospital admissions will be reduced • Consumers' state hospital bed utilization will be reduced • After discharge from this service, consumers will not be readmitted for crisis evaluation and observation services for at least 90 days • After discharge from this service, consumers will not be admitted for facility based crisis services for at least 90 days
22	<p>Service Documentation Requirements</p> <ul style="list-style-type: none"> • <i>Is this a service that can be tracked on the basis of the individual consumer's receipt of services that are documented in an individual consumer record?</i> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <i>If "No", please explain.</i></p> <ul style="list-style-type: none"> • <i>Minimum standard for frequency of note, i.e. per event, daily, weekly, monthly, etc.</i> Minimum standard is a daily full service note per shift that includes the recipient's name, Medicaid identification number, date of service, purpose of contact, describes the provider's interventions, the time spent performing the intervention, the effectiveness of interventions, and the signature and credentials of the staff providing the service. A documented discharge plan will be discussed with the recipient and included in the record.
23	<p>Service Exclusions</p> <ul style="list-style-type: none"> • <i>Identify other service(s) that are limited or cannot be provided on the same day or during the same authorization period as proposed Alternative Service</i> Crisis Evaluation and Observation cannot be billed at the same time as mobile crisis, facility based crisis, inpatient hospitalization, or evaluation services.
24	<p>Service Limitations</p> <ul style="list-style-type: none"> • <i>Specify maximum number of service units that may be reimbursed within an established timeframe (day, week, month, quarter, year)</i> Maximum of 23 hours per crisis event.
25	<p>Evidence-Based Support and Cost Efficiency of Proposed Alternative Service</p> <ul style="list-style-type: none"> • <i>Provide other organizational examples or literature citations for support of evidence base for effectiveness of the proposed Alternative Service</i> <p>Crisis services consisting of observation and evaluation up to 23 hours are well established practices across the country and are generally accepted as effective for intensive evaluation and management of crises as a hospital diversion. http://www.psychservices.psychiatryonline.org/cgi/content/full/51/1/92</p>
26	<p>LME Fidelity Monitoring and Quality Management Protocols for Review of Efficacy and Cost-Effectiveness of Alternative Service For those consumers who receive this service, the following information is monitored. System Level (across consumer served through this proposed alternative service definition):</p> <ul style="list-style-type: none"> • State hospital admissions will be reduced • State hospital bed utilization will be reduced • Recidivism rates for crisis evaluation and observation services will be reduced

	<ul style="list-style-type: none"> Admission rates for facility-based crisis services will be reduced <p>Program Level:</p> <ul style="list-style-type: none"> Consumers triaged as emergent receive CEO services within 2 hours or less after Screening, Triage and Referral Contact is made with the current provider for all consumers open with a provider agency 30 day and 90 day admission rate for facility based crisis services will be reduced
27	LME Additional Explanatory Detail (as needed) N/A